

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9064

State File No.

FILED MAR 19 1952

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5725 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>MACON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>		
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <u>MACON</u>		c. LENGTH OF STAY (In this place) <u>5 DAYS</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDELIA</u>		<u>0804</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>OSTEOPATHIC SANATORIUM</u>			d. STREET ADDRESS (If rural, give location) <u>UNKNOWN</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>JEROME</u> b. (Middle) <u>KOPP</u> c. (Last) <u>SMITH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>02 / 07 / 1952</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED DIVORCED</u>	8. DATE OF BIRTH <u>12-15-1864</u>	9. AGE (In years last birthday) <u>87</u>	# UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD WORKER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (State or foreign country) <u>LOGANSPORT INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN Z SMITH</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH E. RHINEHART</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>PAUL J. SMITH</u> ADDRESS <u>6809 PASEO ST. KANSAS CITY, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>TERMINAL PNEUMONIA</u> ANTECEDENT CAUSES DUE TO (b) <u>SENILE DEMENTIA</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Two days</u>				
19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION <u>NONE.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>NONE</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>NONE</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>NONE.</u>			
22. I hereby certify that I attended the deceased from <u>FEB 3</u> , 1952, to <u>FEB 7</u> , 1952, that I last saw the deceased alive on <u>FEB 7</u> , 1952, and that death occurred at <u>10:02 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Dr. or nurse) <u>Dr. M. Mulkin, D.O.</u>			23b. ADDRESS <u>S.H.O.S. Macon, Mo.</u>		23c. DATE SIGNED <u>2/7/52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2/8/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3/4/52</u>	REGISTRAR'S SIGNATURE <u>185 Ruth Mcneely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Duane Ewing</u> ADDRESS <u>Sedalia, MO.</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
MACON COUNTY HEALTH DEPARTMENT
County File No. 3,16,52
Date Filed 3,18,52

MAR 25 1952

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed *Phane Ewing*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *3847*

P. O. Address *Seale, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.